Appendix 9a
Prior Authorization Therapy Attachment Completion Instructions
(Occupational Therapy)

Do not use this attachment to request a spell of illness; use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Carefully complete the Prior Authorization Therapy Attachment (PA/TA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to:

Attn: Prior Authorization, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/TA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's ten-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Numerical Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 7 - Therapist's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name
Enter the name of the physician referring/prescribing evaluation/ treatment.

Use the remaining portion of this attachment to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element F - Provide the evaluation results (you may attach the therapy evaluation to comply with this requirement).

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the 'Prior Authorization Statement' before signing and dating the attachment.

4. The attachment must be signed and dated by the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, the supervising therapist must sign the attachment.

   The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). If the required documentation is missing from the request form, the request is returned to the provider requesting the required information.

5. Refer to Section III- E of this handbook for additional attachments that may be required.